General HIPAA

About HIPAA

Q. If a claim is error free is it HIPAA-compliant?

A. Not necessarily. HIPAA compliance regulates the format of the claims submission as well as the rules of submission, such as those pertaining to privacy and security. A claim can pass the syntax testing (i.e. Claredi and Validator) and still contain errors in the data submitted or the business requirements for each payer.

Q. Is sending data on a disc considered an electronic transaction?

A. Yes.

Q. Does the law require physicians to buy computers?

A. No, there is no such requirement. However, more physicians may want to use computers for submitting and receiving transactions (such as health care claims and remittances/payments) electronically. The Administrative Simplification provisions of the HIPAA law were passed to support the health care industry. HIPAA law requires that all transactions submitted electronically comply with the standards. Providers, even those without computers, may want to adopt these standard electronic transactions, so they can benefit directly from the reductions in cost. This is possible because the HIPAA law allows providers and health plans to contract with clearinghouses to conduct the standard electronic transactions for them.

Q. Does MDCH expect that the CEO will certify each data submission?

A. MDCH has not yet developed guidelines for that process. It is not required until August 2003.

Q. What is available to help with HIPAA implementation?

A. Testing is currently available. MDCH has contracted with Claredi Inc., to test and certify transactions for HIPAA compliance. Blue Cross Blue Shield of Michigan (BCBSM) and MDCH have contracted with a Foresight tool called the HIPAA Validator for the same purpose. Each mental health PHP and Medicaid Health Plan will be included in this contract and is strongly encouraged to take advantage of this no-cost opportunity. Training is available through Michigan Virtual University at http://healthcare.mivu.org/. These are on-line courses and are available via the Internet 7 days a week, 24 hours a day.

Q. Will date of service determine the claim format after October 1, 2002?

A. No, the date of submission will determine the format after October 1, 2002. You must use the new format for all claims submitted after Oct 1, 2003, despite the date of service.

The schedule for the implementation of the all HIPAA mandated transactions is available on the Michigan Virtual University website at http://healthcare.mivu.org/. These are on-line courses and are available via the Internet 7 days a week, 24 hours a day.

Q. Does the law also require Medicare claims to be submitted electronically after October 2003?

A. HIPAA Administrative Compliance Act (ASCA) prohibits Health and Human Services (HHS) from paying Medicare claims that are not submitted electronically after October 16, 2003, unless the Secretary of HHS grants a waiver from this requirement. It further provides that the Secretary must grant such a waiver if there is no method available for the submission of claims in electronic form or if the entity submitting the claim is a small provider of services or supplies. Beneficiaries will also be able to continue to file paper claims if they need to file a claim on their own behalf. The Secretary may grant such a waiver in other circumstances. CMS will publish proposed regulations to implement this new authority.

Q. Is it true that HIPAA wants the states to give providers one unique number that they can use to bill both Medicare and Medicaid? Is Michigan doing this?

A. Currently Michigan does not have any plans to use the same ID number for both Medicare and Medicaid. Medicare's website is indicating that a Notice of Proposed Rule Making (NPRM) will be coming out recommending the adoption of a national provider identification number which would cover many professions and facilities. This would be done centrally and would apply to all payers, not just Medicare and Medicaid.

Q. Whose responsibility is it to make a provider compliant?

A. The provider is responsible for the data he transmits. The vendor dealing with the provider is responsible for format and compliance. They both will need to work with each other to ensure compliancy. However, ultimately the responsibility will be on the provider to transmit HIPAA compliant claims.

HIPAA Implementation Guide

Q. Where are the implementation guidelines for HIPAA transactions?

A. Michigan will follow the national HIPAA implementation guide found at http://www.wpc-edi.com/hipaa. There will be no Michigan-specific implementation guidelines for HIPAA transactions but MDCH has developed short Companion guides that can be found on the MDCH web site at www.michigan.gov/mdch.

- Click on "Providers" which is found on the left side of the screen
- Click on "HIPAA" which is found on the left side of the screen
- Click on "HIPAA Implementation" which is the last quick-link on the page
- Click on "Companion Guides/Data Clarification Documents" which is in the middle of the page

Q. Please clarify the use of the Implementation Guide and the Clarification Documents.

A. MDCH is using the Implementation Guide (IG) of May 2000 (not the addendum). There are MDCH Clarification Documents on the web for 837 claims and encounters (professional, institutional and dental) that are to be used with the IG, not as a substitute. These are companion documents that clarify content needed by MDCH.

Blue Cross Blue Shield of Michigan (BCBS) also has companion documents on their website to specify content needed for BCBS claims.

Q. Our organization is planning to send the Tax ID in the Billing Provider ID field. Per the implementation guide, the Billing Provider ID is, the EIN, SSN or National Provider ID. Since we don't have a National Provider ID yet, we're currently left with using either the EIN or SSN. Since the SSN applies to individuals and we're an organization, we'll need to use the EIN. Is that a correct interpretation of HIPAA implementation guide?

A. The "Employer ID requirements" (referencing HHS' Standard Unique Employer Identifier Final Rule, published May 31, 2002) relates to identifying employers on standard transactions. While an EIN can be used in various situations on those transactions to identify a provider, the Final Rule concerns itself only with identifying an employer. Use the Tax ID in the Billing Provider ID field NM109 (page 86) with the '24' qualifier indicating Employer's ID number.

Q. What are the implementation guide specifications regarding transaction interchanges in "real-time"? It is important for the healthcare industry to standardize real time versus batch time in order to facilitate communication between providers, payers and intermediaries, etc.

A. The HIPAA implementation guide states the term "Real-time" doesn't imply a set response time. Real-time means that a submitter makes a "connection", submits the interchange and waits for a response without breaking the connection. Monitoring and managing turn-around time is easy when the provider is connected directly, but difficult when the inquiry is from a clearinghouse, since there is no way to know or control the throughput of the entire system. The 270/271, 278, and 276/277 guides all state that the real-time response should be delivered within 60 seconds. The 270/271 and 278 guides go further, stating that the response, a 997 or a TA1, must be delivered within the given time frame. It also limits the number of inquiries on a real-time 270/278 to one—there is no such limitation in the 276 guides.

Q. Does anyone know the history behind how the "Standard" section of the Implementation Guides was developed and eventually turned into the "Implementation" section of the Guides?

A. The "Standard" represents the transaction in its pure, global form, if you will. It reflects all the components that are valid for all uses of the transaction set. The "Implementation" is a road map for how that standard is to be applied to a particular business purpose. Case in point is the 837. As we know, there are three implementations of the 837 mandated under HIPAA -- Professional, Institutional and Dental claims and encounters. The "Implementation" is different for all three, but you'll see that the "Standard" is the same for all, as those are the building blocks of the 837 transaction set.

Q. According to the 837I implementation guide, the reporting of the Attending Physician's EIN or SSN in the 2310A Loop (Segment NM1, Element NM109) is required, and therefore an X12 compliance error will result if this data element

is omitted. This presents a problem given that the EIN/SSN is not available for most of our attending physicians. I have contacted both BCBSM and UGS/Medicare regarding this issue, and both payers will accept a default value of "999999999" for the EIN/Tax ID field. Will MDCH also accept a default value of "999999999" for the EIN/Tax ID field in loop 2310A, NM109?

A. In order to have a HIPAA compliant claim, the EIN or SSN must be used in the NM109 element of the 2310A loop on inpatient claims until such time as the Health Care Financing Administration National Provider Identifier is implemented. As in the case with Medicare, all fields are not currently edited at Medicaid.

HIPAA Implementation Plan

Q. What are the Michigan Department of Community Health's (MDCH) current implementation plans in reference to HIPAA mandated transactions and addenda versions?

A. By October 16, 2003, the Michigan Department of Community Health will have tested and implemented the following transactions:

- 837 Claims and Encounter
- 270/271: Eligibility Request and Response
- 276/277: Claim Status Inquiry and Response
- 278: Authorization/Certification Request and Response
- 835: Claim Payment and Remittance
- 837: Coordination of Benefits

HIPAA Enforcement

Q. What action will be taken against HIPAA covered entities that have not submitted extension requests by October 15, 2002?

A. The Administrative Simplification Compliance Act (ASCA) permits the Secretary of HHS to exclude noncompliant covered entities from the Medicare and Medicaid program between October 16, 2002, and October 16, 2003, if they had not submitted an extension request

Q. Exclusion from Medicare or Medicaid is a severe penalty. Would there be any extenuating circumstances?

A. Yes. Consideration would be given to whether excluding a specific provider could adversely affect beneficiaries' access to care or patient safety.

Q. Who will enforce the HIPAA standards?

A. Department of Health and Human Services (HHS) has determined that The Center for Medicare and Medicaid Services (CMS) will have the responsibility of enforcing the transactions and code set standards, as well as security and identifiers standards when those are published. CMS will also continue to enforce the insurance portability requirements under Title I of HIPAA. The Office for Civil Rights in HHS will enforce the privacy standards.

Q. Doesn't the HIPAA law envision HHS providing technical assistance to the industry to help them become compliant?

A. Yes. HHS enforcement strategy will concentrate on achieving voluntary compliance through technical assistance. Penalties would be imposed as a last resort.

Q. What will the enforcement process look like?

A. The enforcement process for HIPAA transactions and code sets (and for security and standard identifiers when those are adopted) will be primarily complaint-driven. Upon receipt of a complaint, CMS would notify the provider of the complaint, and the provider would have the opportunity to demonstrate compliance or to submit a corrective action plan. If the provider does neither, CMS will have the discretion to impose penalties.

Q. What kinds of penalties could be imposed for non-compliance after October 16, 2003 if they have submitted an extension request?

A. The original HIPAA legislation permits civil monetary penalties of not more than $100 for each violation, with a cap of $25,000 per calendar year. (Much larger penalties are provided for certain wrongful disclosure of individually identifiable health information). Thus, the ASCA penalty is for failure to submit an extension request, and it applies only to Medicare and Medicaid providers, while the HIPAA penalty is for noncompliance, and is generally applicable. Medicare providers could be both excluded and fined, while non-Medicare covered entities would be subject only to the civil monetary penalties.

Q. Will these penalties be imposed on all covered entities that did not submit requests?

A. No. The process leading to these penalties would be initiated primarily in response to an external complaint filed against a covered entity. Once a complaint is received, the entity will have opportunities to avoid penalties by demonstrating compliance, showing how they will achieve compliance by submitting a corrective action plan. Only when an entity does none of these things would consideration be given to invoking civil monetary penalties or excluding a provider from Medicare or Medicaid

Q. How would someone file a complaint against a covered entity?

A. CMS will develop a web-based complaint management process and will provide information on this process as part of our HIPAA outreach activities.

Q. How will CMS publish details about how this process will work?

A. CMS intends to develop regulations that would set out how the enforcement process will operate and how penalties will be imposed.

Q. What should a covered entity that did not submit an extension request do now?

A. They should come into compliance as soon as possible, and should be prepared to submit a corrective action plan in the event a complaint is filed against them.

Q. Will a covered entity that was not in existence prior to October 15, 2002 be subject to these penalties?

A. A newly formed covered entity could utilize a clearinghouse or compliant vendor to become compliant at the time it comes into existence. If the entity is not able to achieve compliance immediately, good faith efforts could be taken into account in the event a complaint is filed. Also, in the event of a complaint, the entity could submit a corrective action plan.

Privacy & Security

Q. What about HIPAA security standards?

A. The proposed Security Rule became final on February 20, 2003, and effective on April 21, 2003. Covered entities, with the exception of small health plans, must be in compliance with the Security Rule by April 21, 2005. Small health plans must be in compliance by April 21, 2006.

Q. What are the changes we need to make to our release of information form?

A. Release of information forms must be compliant with the requirements outlined in the HIPAA Privacy Rule at 45 CFR 164.508. MDCH HIPAA compliant authorization forms can be found on the MDCH website at: www.michigan.gov/mdch -> Providers -> HIPAA -> Authorization to Disclose Protected Health Information.

Miscellaneous

Q. Even though I am a physician, I do not actively engage in the practice of medicine. However, I do provide consulting services to other physicians, such as reviewing medical records for quality assurance purposes, without actually treating the patients. Am I still covered by the Regulations?

A. The circumstances in which physicians are covered by the Regulations are dependent on the activities and functions undertaken by the provider, and not the mere fact that the provider is a physician. Functions that constitute "healthcare" under the Regulations concern the provision of "care, services, or supplies related to the health of an individual". Included may be the following: 1) preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, and counseling, service, assessment or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and 2) sale or dispensing of a drug, device, equipment or other items in accordance with a prescription. The consultation services described above are considered an "indirect treatment relationship" and providers of such services may use and disclose PHI as otherwise permitted under the Regulations and are not required to obtain the patient's consent to use the PHI about the patient for the consultation. The "indirect treatment relationship" exception is covered in more detail in a question below. It is possible that in certain types of consulting relationships a physician may be acting as a "Business Associate", in which case the physician providing such services may be required to enter into a written contract with the healthcare provider regarding the use

and disclosure of the protected healthcare information. The function of a "Business Associate" is addressed more thoroughly in another question.

Please Note: it would be incorrect to assume that every single health-related function is considered "healthcare" under HIPAA. For example, the procurement or banking of organ, blood (including autologous blood), sperm, eyes or any other tissue or human product is not considered to be healthcare under the rule and the organizations that perform such activities would not be considered healthcare providers when conducting these functions.

Q. Is there a database where I can locate Medicaid Provider ID Numbers for claim submission?

A. No. A Medicaid Provider ID Number database is not currently available. This information must be gained through communication with your provider clients.

Q. Is there a database where I can locate Medicaid Referring Provider ID Numbers for claim submission?

A. Yes, there is. The list you are referring to is called the "Referring Providers List". It can be located on the MDCH website. Go to: www.michigan.gov/mdch -> Providers -> Info for Medicaid Providers -> Referring Providers List.